Annual Intake Form

Date:_____________

Patient name: ____ **DOB:**____________ **Age:**___________

HISTORY OF INJURY/PROBLEM

Did a physician refer you to us? □Yes □No Who?____

What problem brings you here today? ________________________________ Side of the body: □ Right □ Left

Which is your dominant hand? □ Right □ Left

Did the problem result from a specific injury? □Yes □No **Injury/Accident Date:** ____/_____/______

Employer: ____________________ Occupation: ___________________ Date last worked:_____________________
Time at current job/employer___________________________
Did your problems begin following: □Work Injury? □Motor Vehicle Accident? When?_______ Where?_______
Claim #______________________
How did your injury occur? ____

____
Is there ongoing litigation? □ Yes □ No
How long have you had the condition? ____
Have you had this or similar problems before?____
Please rate your pain on a scale from 0 to 10 (*10 being the most painful*):
At Best: 0 1 2 3 4 5 6 7 8 9 10 **At its worst: 0 1 2 3 4 5 6 7 8 9 10**
Current: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: □ **Constant** □ **Occasional** □ **Sharp** □ **Dull** □ **Aching** □ **Stabbing** □ **Throbbing** □ **Radiating**

What symptoms are you experiencing? □ **Locking** □ **Catching** □ **Giving Way** □ **Popping** □ **Grinding**
□**Swelling** □**Numbness** □**Stiffness** □**Other** _________________
What, if anything, makes your symptoms *better*? ____

What, if anything, makes your symptoms *worse*? ____

Have you seen another physician for this problem? □ **Yes** □ **No**

If Yes, who? ____ Phone # ____________________________
What treatments have you tried? □ **Nothing** □ **Physical Therapy** □ **Exercise** □ **Acupuncture** □ **Heat/Ice**
□ **Chiropractic** □ **Bracing** □ **Injections** (for example: Synvisc, Hyalgan, cortisone) □ **Rest**
□ **Medications** ________________________________ □ **Other** ______________________________________

Have you had any of the following tests/studies?

Tests:	*Date (month/year)*	*What facility (clinic/ hospital)*
□ **X-rays**	______________________	______________________________
□ **MRI scan**	______________________	______________________________
□ **CT scan**	______________________	______________________________
□ **EMG/NCV**	______________________	______________________________
□ **Discogram**	______________________	______________________________
□ **EKG**	______________________	______________________________
□ **Blood tests**	______________________	______________________________

Patient name: ___________________________ DOB:________

MEDICATIONS

Please **list or attach** all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamins, mineral and herbal supplements.

Medication	*Dosage*	*Frequency*

ALLERGIES

Are you allergic to any medications? ☐ **No known drug allergies**

Please list all medications that you are allergic to: ____

____

Please list all food allergies (i.e. shellfish, eggs): ____

____

Are you allergic to: Sulfa? ☐ Yes ☐ No Latex? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from: ☐ **NONE of the below**

	When?		*When?*
☐ **High blood pressure**		☐ **Osteoporosis**	
☐ **Diabetes**		☐ **Kidney Disease/Problem**	
☐ **Liver Disease**		☐ **Seizures**	
☐ **Heart Disease or Attack**		☐ **Osteoarthritis**	
☐ **Heart Arrythmia**		☐ **Thyroid Disease**	
☐ **Stroke**		☐ **Tuberculosis**	
☐ **Cancer Type:**		☐ **Psoriasis**	
☐ **High Lipids (high cholesterol, etc)**		☐ **Polio**	
☐ **Ulcer Disease**		☐ **Rheumatoid Arthritis**	
☐ **Gastritis**		☐ **Gout**	
☐ **Reflux Disease (GERD)**		☐ **Sleep Apnea**	
☐ **Asthma**		☐ **Fibromyalgia**	
☐ **HIV or AIDS**		☐ **Depression**	
☐ **Autoimmune Disease**		☐ **Hepatitis**	

☐ **Others, please list**: ____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? ______________________

Have you ever had blood clots, deep vein thrombosis or a bleeding disorder? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Please list all surgeries or recent hospitalizations:

Type of Surgery	*Date*	*Surgeon/Location*

Patient name: ___________________________ DOB:________

REVIEW OF SYSTEMS

1) CONSTITUTIONAL
☐ **None** ☐ **Weight changes** ☐ **Chills** ☐ **Fever** ☐ **Weakness/Fatigue**
☐ **Night Sweats** ☐ **Other** _____________________

2) EYES
☐ **None** ☐ **Vision Changes** ☐ **Glasses/Contacts** ☐ **Cataracts** ☐ **Glaucoma**
☐ **Other** _________________

3) EARS, NOSE, THROAT
☐ **None** ☐ **Hearing Loss** ☐ **Ear ache or infection** ☐ **Ringing** ☐ **Hoarseness**
☐ **Sinus Problems** ☐ **Nosebleeds** ☐ **Trouble Swallowing** ☐ **Other**_______________

4) CARDIOVASCULAR
☐ **None** ☐ **Chest Pain** ☐ **Swelling in Legs** ☐ **Shortness of breath**
☐ **Palpitations** ☐ **Murmurs** ☐ **Other** _____________________________

5) RESPIRATORY
☐ **None** ☐ **Shortness of breath** ☐ **Wheezing/Asthma** ☐ **Frequent Cough**
☐ **Sleep Apnea (☐ on CPAP)** ☐ **Other** ___________________________

6) GASTROINTESTINAL
☐ **None** ☐ **Heartburn** ☐ **Acid Reflux** ☐ **Nausea or vomiting**
☐ **Abdominal Pain** ☐ **Incontinence/Frequency** ☐**Other**_____________________

7) MUSCULOSKELETAL
☐ **None** ☐ **Arthritis/Joint stiffness** ☐ **Muscle aches** ☐ **Chronic Back Pain**
☐ **Swelling of joints** ☐ **Other** ____

8) SKIN
☐ **None** ☐ **Rash** ☐ **Ulcers** ☐ **Abnormal scars** ☐ **Sores**
☐ **Other**____

9) NEUROLOGICAL
☐ **None** ☐ **Headaches** ☐ **Fainting/blackouts** ☐ **Dizziness** ☐ **Paralysis**
☐ **Numbness, tingling, loss of sensation in any part of body** ☐ **Seizures**
☐ **Other** ____

10) PSYCHIATRIC
☐ **None** ☐ **Depression** ☐ **Nervousness** ☐ **Anxiety** ☐ **Mood Swing**
☐ **Memory Problems** ☐ **Other** __________________________

11) ENDOCRINE
☐ **None** ☐ **Excessive thirst or hunger** ☐ **Hot/cold intolerance** ☐ **Hot flashes**
☐ **Other** ____

12) HEMATOLOGICAL
☐ **None** ☐ **Easy bruising** ☐ **Easy bleeding** ☐ **Anemia**
☐ **Other** ____

FAMILY HISTORY

Please check family history conditions:

Father	**Mother**	**Sibling(s)**	**Other (aunt, uncle, grandparents):**
☐ **Blood Clots**	☐ **Blood Clots**	☐ **Blood Clots**	☐ **Blood Clots**
☐ **Cancer_ ______**	☐ **Cancer________**	☐ **Cancer________**	☐ **Cancer_______**
☐ **Heart disease**	☐ **Heart disease**	☐ **Heart disease**	☐ **Heart disease**
☐ **Stroke**	☐ **Stroke**	☐ **Stroke**	☐ **Stroke**
☐ **Osteoporosis**	☐ **Osteoporosis**	☐ **Osteoporosis**	☐ **Osteoporosis**
☐ **Diabetes**	☐ **Diabetes**	☐ **Diabetes**	☐ **Diabetes**
☐ **Hypertension**	☐ **Hypertension**	☐ **Hypertension**	☐ **Hypertension**
☐ **Rheum Arthritis**	☐ **Rheum Arthritis**	☐ **Rheum Arthritis**	☐ **Rheum Arthritis**
☐ **Other________**	☐ **Other________**	☐ **Other________**	☐ **Other________**

Please describe any immediate family history medical problems: ____

____

____

Patient name: ___________________________ DOB:________

SOCIAL HISTORY

Marital Status: ☐ **Married** ☐ **Life Partner** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Living Alone** ☐ **Assisted Living**

Children: Male________ Female_________

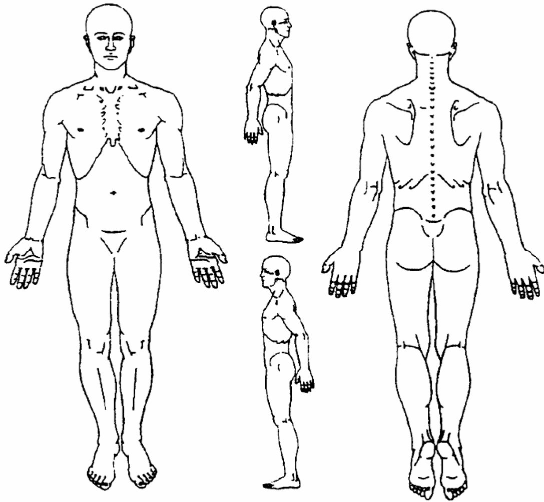
Special Diet: ☐ **Yes** ☐ **No** Any restrictions? ____

Tobacco Use: ☐ **Yes** ☐ **No** Type: ____________________ Duration: _____________ Quit Date: ___________

Alcohol Use: ☐ **Yes** ☐ **No** Frequency: ____

Caffeine Use: ☐ **Yes** ☐ **No** Frequency: ____

Recreational Drug Use: ☐ **Yes** ☐ **No** Type and Frequency: ______________________________



X = Pain/Burning
O = Numbness/Tingling

DUE TO THE NATURE OF OUR SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR. WE APOLOGIZE FOR ANY INCONVENIENCE. WE ARE TRYING TO PROVIDE THE BEST MEDICAL CARE FOR EACH INDIVIDUAL PATIENT.

Signature: ____ Today's Date: _____________

Print Name: ____

Practitioner's Initials/Date _____________ *Practitioner's Initials/Date* _____________

Practitioner's Initials/Date _____________ *Practitioner's Initials/Date* _____________

Practitioner's Initials/Date _____________ *Practitioner's Initials/Date* _____________

Practitioner's Initials/Date _____________ *Practitioner's Initials/Date* _____________

Practitioner's Initials/Date _____________ *Practitioner's Initials/Date* _____________

For Clinical Services Use only: Height: ___________ Weight: _____________BP: _____________
Pulse:_____________ Temp :______________